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THE Hampden Hippocrat

MARCH–APRIL 1995

Medicine At The Top Of The World

The Hampden Hippocrat
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HAMPDEN DISTRICT MEDICAL SOCIETY 1995-1996 SEASON

ANNUAL MEETING

PLACE: **CARRIAGE HOUSE**
Old Storrowton Tavern
West Springfield, MA

DATE: Tuesday, April 25, 1995 SPOUSES ARE WELCOME!

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m.

SPEAKER: State Representative Carmen H. Buell

NOTE: If you must cancel your dinner reservation, please call the HDMS office before noon on April 25th. If the cancellation is not made, you will be BILLED for your dinner.

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THE
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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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From The Editor

This issue of the Hampden Hippocrat takes us to another world with a report on Dr. Paul Helzel's trip to Northern Nepal. Dr. Mark Sherman has prepared a review of the development of pacemakers that is of general intellectual interest. There is also a report on a new network group for medical office staff. Be sure to pass it along if you don't want to get involved yourself.

Brigid Glackin, M.D.
Editor

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Hampden Committee Activities

The Medico-Religious Committee met in January to continue planning for their 11th Annual Medical Ethics Seminar to be held on October 18, 1995. Rev. Michael McCabe, PhD, a Catholic priest from New Zealand, who is employed at Sloan Kettering in New York, was suggested as a possible speaker. He was asked and has accepted to speak on the topic, "A Goal Oriented Approach to End of Life Decision Making". The panel will consist of a physician, a nurse, and a member of the clergy. Several suggestions were given and those mentioned will be approached.

The Public Health Committee was fortunate to have two interesting guests at their January and February meetings. Mr. Robert E. McCollum, Senior Marketing Manager for Junior Achievement of Western MA, attended the January meeting. Mr. McCollum outlined the "Our World" program for 6th graders which teaches global economic concepts-telling children they belong to a world-wide community and stresses personal responsibility, communication skills and the need to stay in school and obtain a good education. He asked if we might be able to find a physician volunteer to attend the three hour training session, and then one session a week with the children for five weeks. Dr. Alonzo Sheffield has volunteered to help with the program in Springfield and Dr. Thomas O'Neil has volunteered for the West Springfield school program.

Dr. Gerald Davoli, of the UMass School of Public Health, addressed the committee members in February. Dr. Davoli suggested we take an advocacy role and a broader stance in the future with prevention programming. He also suggested we work with small communities within Hampden County by contacting their school system's health educator.

The Executive Committee met in January and February. State Representative Carmen Buell has accepted the invitation to speak at our Annual Meeting on April 25, 1995. The committee discussed important issues that developed at the MMS Board of Trustees meeting in January. A consulting firm hired by Mass. Medical Society feels that a community health information network should be established. Governor Weld signed a new law that MPIA become the Medical Professional Mutual Insurance Co. Ownership of the company has been transferred to its policyholders, assuring the Society's role in company governing and rate issues.

Hampden District recently met with Mass. Medical Society's Regional Office and the Girl Scouts of Pioneer Valley. Discussion centered on establishing a program whereby junior high and high school age girl scouts would spend a day with a HDMS women physician member. The date of June 29, 1995 has been chosen and letters have been sent to all of our women physician members asking them to participate. The day will begin with an orientation breakfast and end with a debriefing reception. Both will be held at Mercy's Deliso Center.

It was announced at the February meeting that Ms. Kerin Milesky has been named Director of Governance Services at MMS and Ms. Crystal Hogan has taken on the position of the Regional Coordinator at the West Central Regional Office.

Ms. Barnes reported on a new Prostate Cancer Support Group that has been established. Their first meeting will be March 22, 1995 from 7:00 - 9:00p.m. at Holyoke Hospital. Doctor Gregory Slachta will be the speaker.

The committee also discussed the Medicare VS HMO Blue Liability Recoupments. Dr. Gordan had reported that the problem appears to be resolving itself. Monies Medicare B paid and tried to recoup will be honored by HMO Blue. Physicians will not have to return monies to Medicare B, along with fines for taking more than 30 days. HMO Blue has acknowledged that they are responsible for these physician bills and they are paying Medicare B for these patients.

Our Winter District Meeting, held at the Sheraton Springfield Monarch Place, was attended by 80 members, spouses and invited guests. Dr. Lonnie R. Bristow, President-Elect of the American Medical Association, addressed the group. It has become a tradition for the President-Elect of the AMA to address the Springfield Kiwanis Club the day following our District Meeting. As Dr. Bristow was unable to do so, Dr. Francis VanHouten, President of the Mass. Medical Society, kindly agreed to speak. The Kiwanis Club was very appreciative and kept Dr. VanHouten busy with a lively question and answer period. ■

On Being Role Models

I was watching the local news on television the other night and was shocked by the view of two little boys playfully imitating a fist fight going on between two hockey players on the ice. This was a perfect example of children imitating a display of violence. Kids who spend hours every day watching television cannot help but incorporate some of what they see into their lives. Televised athletic competition presents some of the most influential role models for our children. Some of these media stars get more publicity for their law violations then their athletic performances. Television talk shows, evening news, and special programs all feature stories like Magic Johnson's extra marital sex and HIV, Charles Barkley's brutal basketball antics, Jennifer Capriati's drug use, and Mike Tyson's rape of a model. The recent baseball strike is an example of greed conquering our national pastime. Even fictional characters like Butthead and Beavis, smoking Joe Camel, and those violent Power Rangers present a twisted view of life. And now the U. S. Congress wants to cut funding for the only television network consistently providing worthwhile children's programs, PBS.

Alicia O. M. Ross, M.D., President

But there is hope. The American Medical Association has recently launched a program in collaboration with the Girl Scouts of America called the Physicians of Tomorrow Mentoring Program. Women doctors in the Hampden District will be asked to take a Girl Scout with them one day as they go about their work. Some of these girls may not be influenced to choose medicine as a career, but they will have experienced one worthwhile path in life. There was a time in this country when women were not admitted to medical school regardless of their qualifications. A nineteenth century physician, Dr. James Barry, practiced medicine for many years in Canada, but was discovered to be a woman only after her death in 1865. A similar program should be arranged for Boy Scouts. The mentor program could be a model for other organizations to expose children to real life. Engineers, architects, college professors, and lawyers could show children how their professions contribute to the well being of individuals and society. Every positive experience children have will help to counteract the unrelenting violence they are exposed to every day. ■

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STCC To Offer Medical Record Coding Program

Beginning in September 1995, Springfield Technical Community College will offer a certificate program in Medical Record Coding, according to STCC President Andrew M. Scibelli. He said the program is being instituted due to community demand. "This field has exploded." said program coordinator Mary Ellen Harbeck. "There are now coding departments in all the hospitals, health care facilities, and insurance companies."

Harbeck defined a medical record coding specialist as an "ethical individual who analyzes medical records and assigns codes to index diagnoses and procedures to support clinical care. This person also assists medical research in hospitals, physicians' offices and other health care facilities, and also provides information for reimbursement purposes. Coding is the transformation of verbal descriptions of diseases, injuries, and procedures into numerical designations."

Scibelli said the certificate program will be offered through the Day Division in a one-year program with four or five courses scheduled per semester, and also through the Evening Division in a two-year program with two courses scheduled per semester. The program curriculum is recommended by the American Medical Records Association, and includes pharmacology, a study of human disease, anatomy and physiology, and medical terminology as well as medical coding courses.

Harbeck described the program as highly intensive, in coursework as well as in its focus on computer use. She said that familiarity with computers will be highly beneficial to students. Also, a course in keyboard skills or typing is required before entering the program, unless the applicant can demonstrate keyboard ability through a challenge exam.

Dr. Patrick Tigue, Assistant Vice President for Enrollment Management and Director of Admissions at STCC, said that applications are already being accepted for the Day Division program through the Admissions Office. He said that Harbeck is interviewing all applicants, and a class of 20 students will be accepted. The Admissions phone number is 781-7822 extension 3855.

For information on availability of the Evening Division program, interested individuals should call the Division of Continuing Education at 781-1315. ■

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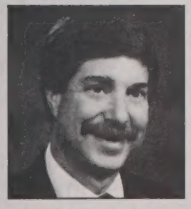

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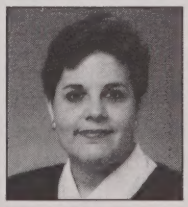

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Medicine At The Top Of The World

by Brigid K. Glackin, M.D.

In December, 1994, Dr. Paul Hetzel spent three and a half weeks "trekking" the mountains of northern Nepal. He hiked to eighteen thousand feet to the area where climbers begin their assault on the major peaks of the Himalayas. Paul had wanted to make this trip ever since he wrote a report in high school on Edmund Hillary's successful climb to the summit of Mount Everest in 1953. Obstacles to visiting the area included its remoteness and the very real risk of serious illness if the trip wasn't carefully planned.

Through Dr. George Karras, the intensivist at Mercy Hospital, Paul found an able guide in Peter Owens of San Mateo, California. Owens had been traveling and leading groups to Nepal and the Himalayas for twenty five years. His tours were remarkable for their meticulous planning. As the tour leader, Owens was responsible for all of the land arrangements once the group left the Nepalese capital of Kathmandu. The plan was to traverse an area accessible only on foot, carrying all the food and equipment that would be needed. The goal was to reach the Gokyo Ri, an 18000 foot peak in the shadow of the 29,085 foot Everest.

Paul was the only physician among the group's thirteen participants. The ages ranged from a married couple in their thirties who were foresters to a sixty-eight year old woman. Other local participants included a Springfield auto dealer and a Deerfield musicologist with a strong interest in Buddhism, the predominant religion of northern Nepal and of Tibet.

Nepal is a country the size of New York state with a population of eighteen million. It is surrounded on three sides by India and lies in the same latitude as Miami. Southern Nepal has tropical rainforests and is fairly densely populated. A military road built by the British in colonial times traverses the one hundred kilometers from sea level at the Indian border to the capital of Kathmandu at four thousand feet. Over the past forty years, since Nepal opened its borders to foreigners, Kathmandu has become a sprawling third world capital of three hundred and fifty thousand. The city has cows and water buffalo wandering the narrow streets and pigs chasing them to consume their offal. There are open sewers and wild dogs. There are religious shrines sacred to Hinduism, the religion of many Nepalese. Temples are filled with wild monkeys, gigantic prayer wheels, and monks in saffron robes dedicated to Tantric Buddhism. This is the religion of Nepal's northern tribes of Sherpas and of Tibetans who have migrated to Nepal following the takeover of Tibet by China. On clear mornings in Kathmandu, the first range of mountains to the north–at ten thousand feet–are visible. Multiple twenty-five thousand foot peaks, always in snow, appear out of the mist above the rest.

Nepal is a country the size of New York State with a population of eighteen million.

Paul flew to Kathmandu via Los Angeles and Bangkok. He spent a few days there acclimating himself to the eleven hour time change and the altitude. He then continued in a Russian surplus helicopter–left over from the war in Afghanistan–on a nail biting trip to Lukla at 9200 feet. There he joined the group that had been walking for a week. The route led into a sparsely populated area, not accessible by motorized vehicles. Most freight coming into the area is carried in by people. Typically, porters carry about a hundred pounds in a bundle suspended from their heads by a leather strap, as they climb the stony, narrow switchback trails barefoot or wearing rubber thongs. Above the tree line, the route offered spectacular views of the gigantic peaks to the north as the group approached the chain of peaks at the roof of the world that form the boundary between Nepal and the high plateaus of Tibet.

The physical preparation for the trip on Paul's part included walking the local trails in the Holyoke Range while breaking in his hiking boots over several months. Paul also continued his long-standing routine of running thirty to fourty miles per week. Temperatures during the trip ranged from tropical eighties in Bangkok to the sixties in Kathmandu. Once the elevation increased, nights were at 5° to 20° F and the sun in the daytime could be punishing without sunscreen. Tour members were given a very precise list of recommended gear. They were allowed only twenty-two pounds each and, for example, only three changes of underwear were recommended. The porters accompanying the group carried thirty kilos each, or the luggage of three people. Additional personal effects could be carried in a daypack but no more than ten pounds was recommended. One enterprising couple carried a solar powered battery that was capable of powering their video camera. Laundry could be hung from backpacks during the day or dried over cook fires at night.

Above ten thousand feet, the group took Diamox daily to prevent elevation sickness and the resulting pulmonary edema. This resulted in Paul's report of the frequent sound of unzipping and rezipping of tent flaps as the so-called mild diuretic relieved any incipient pulmonary congestion. The trip was planned so as to not ascend more than one thousand feet in one day. While all of Paul's group did well, two tourists on other hiking expeditions died during their time there.

It took approximately ten days to walk the route to Gokyo Ri at eighteen thousand feet, and the same time again to walk out. This route was chosen, instead of walking to the base camp of Everest, because it was a route less traveled and offered opportunities to see glacial lakes and terraced valleys. The trekkers were awakened daily at sunrise by the congenial cooks accompanying them with "Good Morning, NEPAL!" and a cup of sweet tea and creamy water buffalo milk. During this season before the monsoon (which begins in April), the mornings were always clear as the sunrise hit the high peaks. By two in the afternoon the mists would rise, obscuring some views and making others more mysterious. Camp was set up by sundown. The area is without electricity except in the form of occasional generators. Wild rams or tahrs could be seen and also yaks which are, according to Paul, enormous. Rivers were crossed using hand made suspension foot bridges of logs or planks that swayed crazily as they were crossed. The mountain passes are often decorated with Buddhist shrines–tattered prayer flags and piles of stones to commemorate those who have died along the way from falls during the harsher seasons, which are windier and colder.

Paul had the opportunity to visit the area hospital at Kundi. This facility is run by volunteer doctors from Canada and New Zealand. It was founded by Sir Edmund Hillary. After his conquest of Everest in 1953, Hillary had remained involved in and concerned about Nepalese life. He was most recently high commissioner from New Zealand to the Nepalese government, in 1984. His wife and daughter were killed on a flight from Kathmandu after a crash near Kundi. Hillary helped to found the hospital there in their memory.

The Kunde Hospital that Sir Edmund Hillary helped to found.

Primary care doctors here would be interested to know the doctors at the Kundi Hospital report that ninety percent of the patients present with colds or sore throats. The commonest reason for hospitalization is tuberculosis or frostbite. The median mortality for Nepalese nationally is age 51. The Kundi Hospital has been able to increase this to age 65 in their area. This has come about primarily through a decrease in perinatal and infant mortality. The improvement is attributed to the influence of prenatal visits and nutrition, vitamins and immunizations. It is not due to hospital care at the time of delivery because most women

Continued on next page

Medicine

Continued from previous page

in these rural mountains deliver at home. When asked if anyone dies of cancer, doctors replied that they really would not know because they have plain x-rays only.

Other highlights of the trip included a visit to the major Sherpa village of Namche Bazaar on Saturday, the principal market day. The Sherpas are the mountain tribe that inhabits this region between Tibet and Nepal. They are legendary for their mountaineering skills and have assisted many foreign mountain climbing expeditions to the Himalayan summits. Also seen was the rugged Buddhist monastery at Thangboche which was largely destroyed by fire in the 1980s, but later rebuilt.

The Nepalese government has welcomed foreign visitors as an economic boon to an area that is largely uncultivatable. However, the years of foreign expeditions have taken their toll, largely in the form of garbage–discarded and frozen forever. The government is cleaning up the mess of the last forty years with funds obtained from admission fees to the areas of the base camps, which have been designated in the Western style as a national park. Individual trekkers are charged about $13. Members of climbing expeditions planning to assault the summits are assessed $50,000 a climber.

Paul found the rewards of the trip to be primarily visual and took over 700 pictures. Some of those are included here. He found that the participants had in common their enjoyment of "adventurous vacations." This trip gave him the opportunity to fulfill a desire, born as a teenager, to explore a remote area with an ancient, distinct and isolated culture. It also offered a physically challenging quest with rewards of visually stunning landscapes. ■

Brigid Glackin, M.D.

Paul Hertzel is a Medical Oncologist who practices with Springfield Medical Associates at 2150 Main Street in Springfield

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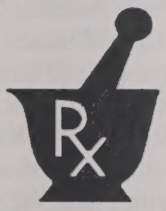

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In Memoriam

Dr. Peter J. Krokidas, 56, of Chicopee died February 20, 1995 at Baystate Medical Center after a long illness. He was an ophthalmologist, and the owner and operator of the Western Massachusetts Eye Association on Montgomery Street. He ran the business for more than 25 years, and was licensed in five states. He was a founder of the Medical West Health Campus. He was a past president of the Lions Club and the city's Historical Society, and was a Moose. He belonged to the Chamber of Commerce, and was a city health commissioner from 1987.

He was a member of the Harvard Club in Boston, and several branches of the Yale Club. He was awarded a Connecticut Valley Yale Club Scholarship. He received a state medical scholarship; the University of Massachusetts Pre-Med Club Award for teaching; state civic awards for organizing and directing free eye clinics; the American Medical Association Physicians Recognition Award, and governor's and area citations for civic clinic work.

He published several articles, lectured on area television and radio stations, and instructed senior citizens.

He was in the Hampden District and Massachusetts Medical Societies.

Born in Springfield, he was a 1956 graduate of the former Classical High School. He received a bachelor of arts degree from Yale University in 1960.

He received his medical degree from the Medical College of Virginia at Richmond in 1966, and served his internship there. He served his residency at the University of Maryland in Baltimore, and the University of Pennsylvania in Philadelphia, where he was an instructor of ophthalmology in 1969-1970.

He was a general physician in emergency rooms and outpatient clinics in the Army Reserve in 1972-1975, and was a major in the Air Force Reserve in 1980-1984. He was a Federal Aviation Administration medical examiner from 1982.

He lived here most of his life, and attended the St. Constantine and St. Helen Greek Orthodox Church. He had been an altar boy at St. George's Greek Orthodox Cathedral in Springfield. He leaves a son, John R. of Woodbridge, CT; a daughter, Stephanie Krokidas of Woodbridge; his mother, Catherine (Hyfantis) Krokidas of Springfield; two sisters, Simone Arakelian of Springfield and Maria Krokidas Bullen of Weston; nieces and nephews, and his fiancee, Niki Ferros of Granby. ■

Current Cardiac Pacemakers

A Triumph of Technology Over (Nearly) Everything

by Mark M. Sherman, M.D.

The "Hippocrat" editors have challenged me to update the readership on the subject of cardiac pacemakers. I have challenged myself to confuse no more than 5% of psychiatrists and dermatologists, but to bore no more than 5% of cardiologists. Other specialties should fall between these extremes.

A modern cardiac pacemaker consists of two components: (1) a pulse generator - which contains the circuit boards and the energy source (batteries) sealed in a can, and (2) a pacing catheter - an insulated metal conductor composed of a connecting terminal at one end, the catheter itself, and the stimulating electrode at the tip; which (a) transmits an electrical pacing stimulus to the endocardium, and (b) transmits a cardiac signal (P wave or QRS complex) back to the pulse generator.

In the mid 1970s when I was a Thoracic Surgical resident learning to implant permanent cardiac pacemakers, 90% of my pacing catheters were implanted via the transvenous route and 10% via the epicardial/myocardial route (open thoracostomy). Nearly all implants were single chamber devices. The pulse generators, which weighed about 180 grams (6 ounces) were non-programmable, "demand" units which were set at one pacing rate; they were predisposed to frequent random component failures. The energy source was mercury zinc batteries. On average, the units lasted about two years. Now, twenty years later, I implant pacing catheters exclusively via the transvenous rather than the epicardial/myocardial route. (Interestingly, endocardial electrodes are known to pace and sense more effectively than myocardial electrodes). I have not seen the need for a myocardial electrode for at least fifteen years, and I do not anticipate seeing a patient with such a need. Pulse generators now weigh 20-40 grams (1 ounce). They are powered by lithium batteries. The random component failure rate is practically 0. They last, on average, seven to eight years. With a small external computer/programmer, the pulse generators can be programmed to many different pacing modes, rates, outputs, and various physiologic settings (probably 50 million or so possible different combinations of settings per unit). Many units pace both the atrium and the ventricle rather than a single chamber. The units are costly however (often $4,000 - $6,000).

With a small external computer/programmer, the pulse generators can be programmed to many different pacing modes, rates, outputs, and various physiologic settings.

The history of cardiac pacing could fill many volumes; however, even a short review such as this demands some acknowledgement of the past. Morgani (1761), Robert Adams (1827), and Robert Stokes (1846) provided the eponym "Adams-Stokes-Morgani disease" for complete heart block associated with syncope. The term heart block was introduced by Gaskill in 1883. Aldenini (1819) tried to directly stimulate the heart of decapitated criminals using a voltaic pile. Marmorestein (1927) successfully paced the intact dog heart. Hymen (early 1930s) produced and was issued a patent on a large external cardiac pacemaker powered by a magneto generator. Zoll (1952) paced clinically the human heart with an external pulse generator. The major stimulus, however, to the development of modern, implantable, permanent cardiac pacemakers was the first demonstration of successful cardio pulmonary bypass in the human in 1953 and the subsequent rapid onset of "open-heart surgery,"

particularly at the University of Minnesota. Many of the early operations were in young children with congenital heart disease. Particularly, repair of tetralogy of Fallot and ventricular septal defect often led to surgically induced complete heart block which, in the absence of available pacemakers, was often fatal to these young children who had otherwise had successful repairs of their congenital heart defects. Weinrich, Gott, and Lillehei, therefore, in 1957 reported the clinical feasibility of direct bipolar electrical stimulation of the myocardium with stainless steel electrodes which exited the closed chest to connect to an external battery-operated pacemaker to sustain life in the early post-operative period. In 1958, Furman and Robinson demonstrated the short term feasibility of stimulation of the human heart with a transvenously applied unipolar cardiac pacing catheter, and in 1959, Furman and Schwidel demonstrated the long term application of transvenous cardiac stimulation in the human. Subsequent major advances involved the development of lithium batteries in the mid 1970s, solid state circuitry, multiprogramability, and dual chamber "universal" pace makers. As well, there were major advances in lead technol ogy and in pacemaker monitoring systems. This dramatic triumph of technology over disease has resulted currently in the annual implantation of 136,000 pacemakers in the United States and 347,000 implants annually in the world. Currently, there are 1.2 million pacemaker patients in the United States and 2.7 million pacemaker patients in the world.

Consider advances in three different areas - energy sources, leads, and pulse generators. The batteries for the first implantable pulse generators - from the late 1950s through the mid 1970s were mercury zinc batteries. As a byproduct of the chemical reaction, hydrogen gas was produced in small amounts, but sufficient to preclude hermetic sealing of the pulse generator. The pulse generator therefore was suspectible to tissue fluids entering and causing malfunctions. Thus, the original pulse generators were prone to random component failure and often failed suddenly, resulting in problems due to either "runaway pacemakers" or sudden failure of output in pacemaker-dependent patients. It was therefore a major mile stone in the mid 1970s when advances in battery technology led to the production of lithium batteries. The chemical reaction produced no gas, and accordingly the pulse

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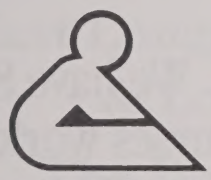

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Continued from previous page

generator could be hermetically sealed. This, in conjunction with the development of solid state circuitry, has resulted in a random component failure rate of practically 0. Additionally, the battery life for lithium batteries is longer by several years than that of mercury-zinc batteries. For a number of reasons, there has been little current interest in producing nuclear-powered batteries (which would have a much longer longevity). Similarly, externally rechargable energy sources have all but been abandoned.

Advances in lead technology have been at least as dramatic. Plastics chemistry research has resulted in poly urethane being the insulator of choice for pacing catheters. Early pacing catheters used silicone for insulation. The polyurethanes are more durable and allow a thinner coating of the insulator, thereby resulting in a lead of smaller diameter. Methods of lead fixation to the endocardium have improved. Early leads had simple flanges at the tip to accomplish "passive" fixation within the trabeculae of the right ventricle. The lead displacement incidence was not inconsequential. Subsequently, small fishhook-like barbs were developed to more reliably entrap the electrode in the RV trabecule. These barbs fix very well in most ventricles, but have a somewhat higher displacement rate in the less well-trabeculated right atrium or RA appendage. Multiple different "active fixation" devices have been devised; the device most often used currently is a "screw-in" fixator which consists of a corkscrew-like helix which, when the lead is appropriately positioned, is screwed into the ventricular or atrial myocardium. In an attempt to prevent scar tissue build-up (and ultimate "loss of capture") at the electrode-endocardium interface, electrode tips have been developed with tiny volumes of steroid solution which is slowly released to cut down the inflammatory reaction and keep the stimulation thresholds down at acceptable levels.

Two pulse generator advances will be described here: rate-responsiveness and automaticity. Early pacemakers were preset at only one pacing rate. Subsequent pacemakers could be programmed at fixed points in time to different, but fixed, rates. It was obviously desirable to develop a sensing mechanism which would

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increase the pacing rate as physiologic demands required. (Fever or activity demanding faster rates; sleeping periods requiring slower rates). A number of rate sensors have been tried, including, but not limited to, gross bodily motion, minute ventilation (based on chest wall impedance) and core temperature (detected by a thermister at the tip of a catheter). Currently, either of two sensors are most often used. Most frequently, the sensor is a piezoelectric crystal, which is sensitive to gross physical motion and compression and decompression. This is based on the presumption (usually true) that if a person is walking, running, or otherwise moving, he or she requires a faster cardiac rate, and that if he or she is still (i.e. sleeping or sitting) his or her cardiac rate could be lower. A "false positive" might be sitting in a vehicle bouncing along a rough road. A false negative might be sitting still with a temperature of 106 degrees F. A second type of rate responsive system utilizes sensors to detect impedance across the chest wall, which impedance is related to minute ventilation. The greater the minute ventilation, the faster the pacing rate; the lower the minute ventilation, the lower the pacing rate. The threshold for rate response, the increase of rate over time and the decrease of rate over time are all programmable.

Automaticity in pacemakers is currently being stressed; two examples only will be described - automatic mode switching, and automatic PR interval changing. If a patient with severe symptomatic sinus bradycardia and third degree AV block has a DDD (dual chamber) pacemaker in place, that individual's rhythm strip would show atrial pacing followed by ventricular pacing. If such a patient went into atrial fibrillation, one would not want the atrial lead to track the atrium. In past years, (as recently as a few months ago), the physician would have had to notice this rhythm change, bring the patient to the office or hospital and program the patient out of the dual chamber mode into a ventricular pacing mode. With automatic mode switching, pacemakers have an algorithm to automatically diagnosis this change of rhythm and to act upon it by automatic mode switching converting to a ventricular pacing mode - eg, "demand" ventricular pacing (VVI or VVI-R). All automatically!

A second area of automaticity currently available is PR interval changing. As the human heart increases its rate, there is a normal gradual shortening of the PR interval. Also, the optimum programmed AV delay should be longer after a paced atrial beat than after a sensed atrial beat.

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Over the past few years, external programming provided only one AV delay for a sensed, and one for a paced, atrial beat. Current generations of pulse generators, however, now include the automatic function of PR interval changing, both after paced and sensed atrial beats, when the heart rate changes - either native changes or changes based on rate responsivity. For example, as a pacemaker patient's heart rate gradually increases, due either to the rate responsive feature of the pulse generator, or due to normal chronotropic competence of the patient's heart, the AV delay will gradually shorten, both after a sensed or after a paced atrial beat. This feature then more typically mimics normal cardiac function.

Finally, I would close by listing just a few matters of some concern to me regarding pacemaker patients. (1) There are many areas in the Third World where pacemakers cannot be afforded for the population, even for the most basic indications such as 3rd degree heart block with syncope. In an affluent country such as ours where many patients die and are buried with pacemakers which have years of useable life left in them, it has always concerned me that issues such as legal liability, among others, have prevented ex planting and cleansing such units and distribution of them to Third World countries. (2) The current use of subclavian vein puncture for venous access for pacemaker catheter placement has the attendant morbidity, or even mortality, to that approach. Many years ago, we used open cutdown on the cephalic vein as the site of venous access. This had essentially no vein-related mortality or morbidity. (3) Since current pacemaker technology is so complex, and since many people reading EKGs do not maintain currency with cardiac pacemaker advances, one should be aware that it is impossible to determine if a pacemaker is functioning properly without knowing exactly what are the programmed settings of that pacemaker. (4) Many patients with implanted pacemakers have not used their pacemaker (i.e. been shown to have paced) for over a decade. What should be done, if anything, in such a case?

In summary, current cardiac pacemaker technology is certainly a triumph of technology over disease. It is a triumph in patient management. It is a challenging triumph in medical ethics. And it is a most challenging triumph for medical economics. ■

Dr. Mark M. Sherman practices Thoracic Surgery at 2 Medical Center Drive in Springfield.

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A Network for Medical Office Staff

by Brigid K. Glackin, M.D.

Helene Murthy has organized a group of medical office staff and physicians who are meeting in response to the changes brought about by managed care policies. These policies, in the group's view have diluted the quality of patient care. An onerous burden of paper work has been imposed. The system has become increasingly difficult to navigate from both a medical practice and a patient standpoint.

Mrs. Murthy's interest in this area arose from her role as the manager of her husband Kollegal Murthy's oncology practice. She was concerned about the effects of micromanagement by organizations that pay for health care on their individual patients. She felt that really sick patients were being placed at risk, because of delays in care or denial of the referral process. Doctors were expected to have ultimate responsibility for the well being of the patient, but were losing control of the patient's care.

When Medicare payment rules were drastically overhauled two years ago, Mrs. Murthy decided that a grassroots effort was needed to alert the public to the prospects for the decline in the quality of care. She had worked as an individual to organize patients themselves to write to politicians and government administrators regarding payment practices that were threatening their health and peace of mind. When asked why she decided to try to organize others around these same issues, Mrs. Murthy cited two reasons. One reason was a pragmatic one–she found that an individual office complaining about a payment practice would often be told that "no one else was having this problem." She also wanted to overcome a sense of isolation she felt.

Helene Murthy's background in social work, she believes, was an important element in the way she has approached these problems. She feels her training in group work and community organizing has been helpful in getting the group started. She has also emphasized improved relationships as a key to change.

The group Murthy founded has been meeting two or three times a year since its inception. Currently about forty people usually attend. A strategy of the group has been to improve relations with individual payment intermediaries. Medicare itself had previously organized informational meetings for medical office staff. These were generally too large and unfocused to allow effective discussion of specific problems. Medical office staff were angry at the *manipulation* that seemed inherent in rates and code changes that tended to deny payment for care

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already rendered. At one point, area hospitals had scheduled "breakfasts" for medical office staff to discuss problems of mutual concern, but these have been discontinued.

The group has had as guests at their meetings, representatives from Medicare, Blue Cross Blue Shield, Cigna and Health New England. A continuing concern of the group has been the threat to the quality of patient care posed by managed care. Meetings scheduled with politicians or their representatives on this issue have been less successful. The press has also declined to engage in a dialogue on these problems, although at first interest was expressed.

An example of a problem that was addressed by the group was the refusal of HMO Blue to allow area physicians to enroll as new providers. HMO Blue changed their stance on this issue after meeting with the medical office staff network group. A type of program the group has been calling for is the opportunity to discuss specific unpaid or problem claims with payors. Recently, the Massachusetts Medical Society has setup meetings in its regional offices in Holyoke and Lakeville and also at the Worcester District Medical Society to permit individual medical office staff to meet with representatives from Medicare and Medicaid regarding specific unpaid claims. The meetings are being held April 19, May 10 and June 14, 1995. Further information is available through the MMS regional office at (413) 534-1100 or 1-800-522-3112.

Mrs. Murthy would like the group she has launched to become more formalized. Most of the group's meetings have been held at Mercy Hospital, because the use of room was donated there. Communication has been by postings on medical staff bulletin boards. The medical staff office at Mercy and the volunteers there have assisted with distributing the group's flyers and with typing. Options for improved communication for the group include "adoption" of the group by HDMS or small donations at individual meetings. Anyone with ideas or energy who wants to become involved in this networking effort should contact Helene Murthy at her office at 292 Carew Street, Springfield, (413) 739-4085.

An accomplishment of the group has been to establish key contacts as a result of meeting with various payors and managed care organizations. Mrs. Murthy encourages other offices to share the names and addresses of other contacts with her networking group.

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Premed: Boston College 1975-1979
Medical: Georgetown University School of Medicine 1980-1984
Internship: Wilford Hall USAF Medical Center, TX 1984-1985
Residency: Wilford Hall USAF Medical Center 1985-1987
Fellowship: Wilford Hall USAF Medical Center 1987-1990
Specialty: Internal Medicine/Cardiology

Alan W. Kulig, M.D.
Springfield Anesthesia Service
P.O. Box 1330
Springfield, MA 01101

Born: August 25, 1959
Premed: Whitman College, Washington 1977-1982
Medical: University of Connecticut 1983-1987
Internship: Baystate Medical Center 1987-1988
Residency: Baystate Medical Center 1988-1990
Fellowship: Cleveland Clinic, Ohio July 1990-December 1990 Cardiothoracic Anesthesia
Yale University, CT January 1991-June 1991 Neuroanesthesia
Specialty: Anesthesiology

Richard P. Anderson, M.D.
80 Congress Street
Springfield, MA 01104

Born: November 28, 1958
Premed: North Park College, Illinois 1976-1981
Medical: University of Connecticut School of Medicine 1982-1986
Internship: West Virginia University Hospital 1986-1987 (General Surgery)
Residency: West Virginia University Hospital 1987-1992 (Neurosurgery)
Fellowship: Allegheny General Hospital, Pennsylvania 1990 (Neurosurgery)
Specialty: Neurosurgery

Stuart A. Dunbar, M.D.
Springfield Anesthesia Service
P.O. Box 1330
Springfield, MA 01101

Born: July 26, 1959
Premed: Trinity College, Dublin, Ireland
Medical: Trinity College, Dublin, Ireland 1978-1984
Internship: Nassau County Medical Center, New York 1989-1990
Residency: Brigham & Women's Hospital, Boston 1990-1993
Fellowship: Brigham & Women's Hospital July 1993-December 1993
University of California, San Diego January 1994-December 1994
Specialty: Anesthesiology/Pain Management

Michael K. Magee, M.D.
Springfield Anesthesia Service
P.O. Box 1330
Springfield, MA 01101

Born: November 30, 1962
Premed: University of Oklahoma 1981-1982
NW Oklahoma State University 1983-1986
Medical: University of Oklahoma College of Medicine 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-1994
Specialty: Anesthesiology

Ronald T. Burkman, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: June 24, 1943
Premed: Cornell University 1961-1963
St. Lawrence University, NY 1963-1965
Medical: Albany Medical College 1965-1969
Internship: University of Washington, Seattle 1969-1970
Residency: Albany Medical Center, NY 1970-1973
Specialty: Obstetrics/Gynecology

IPA\PHO NEWS

Western New England IPA

PHO development continues in the Pioneer Valley. The Sisters of Providence PHO Development Committee has recommended that the *Western New England IPA* accept the "hybrid model" PHO. This structure allows physicians to join the PHO as individuals. Under this proposal, there would be no formal relationship between the PHO and WNEIPA. There is a significant faction of physicians who do not favor this structure and negotiations are ongoing.

GSIPA

The Nominating Committee of the Greater Springfield IPA with Dr. John Egelhofeas chair circulated a letter soliciting nominations for the boards of GSIPA, the PHO, Baystate Health Partners, and Health New England. This is in response to complaints last year that membership on these boards was somewhat restricted and self perpetuating.

Cooley Dickenson

Dr. Jay Fleitman is the president of a PHO forming at CDH. The PHO was formed in late November and a membership drive meeting was held February 6, 1995.

Holyoke Regional IPA

HRIPA met with Mr. Ronald Himmelgarn of GSIPA regarding the use of an RBRVS system as a method of physician reimbursement for Health New England. The guest at the annual meeting was the executive director of Health New England, Mr. Richard Beloff. He discussed HNE's negotiations to become a Medicare HMO. HRIPA is working with Holyoke Hospital to form the PHO, Valley Health Partners.

The Massachusetts Medical Society's Committee on Managed Care is developing a Managed Care Hassle Factor Program. The program is being designed to help physicians cut through red tape and resolve problems with third party payors. They have developed a Hassle Fact Form which is available through MMS's Department of Health Systems and Policy. FAX (617) 893-8009. ■

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MMS Executive Briefs

MPIA Mutualization Bill Signed

On January 11, Governor William Weld signed into law the bill to convert the MPIA (Massachusetts Medical Professional Insurance Association) into the *Medical Professional Mutual Insurance Company*. The bill, which was the Society's major legislative priority for the 1994 session, will transfer ownership of the company to its policyholders and preserve the Society's role in company governance and rate issues. The process is to establish control of the Commonwealth's largest medical professional liability insurer by its insured physicians.

MMS Testifies On Children's Medical Security Plan

The MMS urged continued efforts to "maintain, expand, and improve health care services for children" in testimony before the Joint Committee on Health Care last week concerning the *Children's Medical Security Plan (CMSP)*. New enrollments for the state plan, which provides primary and preventive care services to an estimated 21,000 children under thirteen, were frozen in late December. The Society's testimony on January 12 commended the legislature and the Department of Medical Security for improving children's access to care, noting that plan enrollments doubled last year, but the MMS also urged that such services need to be extended to as many children as possible. The Society had joined with Health Care for All and other groups the day before in calling on the Weld administration to re-open CMSP enrollment.

Medical Community Condemns Health Clinic Violence

The MMS joined with other members of the Massachusetts medical community in condemning the December 30 shootings at two Brookline health clinics that left two female workers dead and and five others injured. The alleged assailant, a New Hampshire man known to have anti-abortion views, is being held in Norfolk County Jail after being arraigned on charges related to the incidents. In a statement released on December 30, the Society termed the shootings "abhorrent" and declared that "no health-care employee or patient should have to

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MMS Executive Briefs

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have his or her life threatened because someone disagrees with an organization's philosophy or policy."

State Ok's Harvard–Pilgrim Merger

The August 1994 announced merger of health insurers *Harvard Community Health Plan and Pilgrim Health Care* was completed after receiving final approval from Massachusetts Attorney General Scott Harshbarger. The companies are expected to operate separately for another year until the actual integration is completed. According to the *Boston Globe*, the merger received final approval when the plans agreed to freeze rates for individual and small group policies, hold premium increases for other policies to 2 percent, and pay an additional $3 million to provide AIDS education, violence prevention, and health care for the homeless.

Partners, Blue Cross & Blue Shield Announce Collaborative Agreement

At a January 5 press conference, *Partners HealthCare System and Blue Cross and Blue Shield of Massachusetts* announced they had signed a memorandum of understanding to integrate health service delivery, financing, and marketing, as well as to jointly develop new products and services for the Massachusetts health care market. As part of the collaboration, Partners (the organization overseeing the affiliation of Mass. General and Brigham & Women's hospitals) and the Blues are working on three specific initiatives: a new managed care product for seniors, jointly staffed health centers, and an integrated information system. The seniors' managed care product is in keeping with a growing trend to move elderly patients into Medicare HMO-type plans, while the joint staffing arrangements will incorporate Partners' providers into existing Blue Cross/Blue Shield sites in Braintree, Peabody, Methuen and Framingham. The integrated information system will seek to link patient information (including medical histories, prescriptions, and laboratory work) from physicians' offices, hospitals, and other network providers. ■

Practice Changes

Alan J. Stark, M.D. has left the Department of Radiation Therapy at Baystate Medical Center to become Medical Director of the new Sr. Mary Caritas Center for Oncology at Mercy Hospital, Springfield as of January 3, 1995.

Ronald W. Greenwood, M.D. has joined Drs. Glasser, Raman, Rao and Peck at Valley Pulmonary and Medical Associates, practicing Pulmonary and Internal Medicine in Springfield and Chicopee.

Drs. Leonard Shaker, Oscar Elguero, Michael DeCenzo, David Kelley and **Sandy White** have combined their Urology practices and are practicing together as Valley Urology with offices in Westfield, Springfield, Holyoke and Ware.

Dr. Gregory Grenzke has retired from the practice of general and vascular surgery after practicing locally since 1979, effective March 1, 1995.

J. Gordon Rich, M.D. has resumed his practice of Orthopedic Surgery at 401 Chestnut Street, Springfield after a hiatus caused by Guillain-Barrè Syndrome.

Drs. David Ballan, Eugene Boss and **Jeffrey Cossins** have closed their individual practices and formed Northern Edge Medical Associates under the auspices of Baystate Health Systems. They are practicing Internal Medicine at 3455 North Main Street, Springfield. ■

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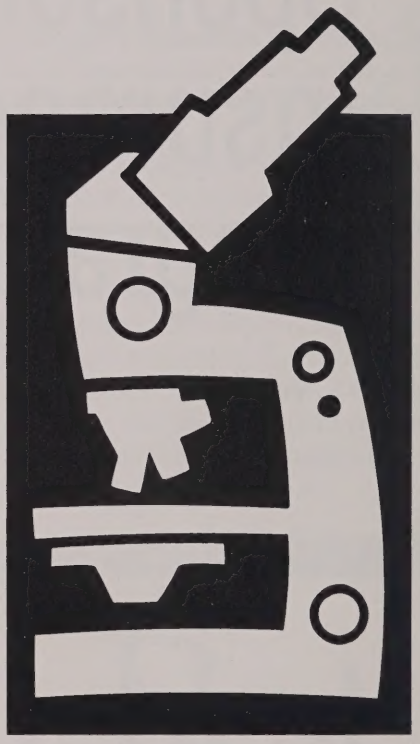

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For more information
contact John McGowan at 748-9525

Life Laboratories is a member of the Sisters of Providence Health System